State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

HOSPITAL INPATIENT REIMBURSEMENT PLAN

REIMBURSEMENT PRINCIPLES

Effective for discharges occurring on or after January 1, 1995 acute care general hospital inpatient services shall be reimbursed using a Diagnosis Related Groups (DRG) system, except as noted in EXCEPTIONS TO DRG REIMBURSEMENT section of this plan.

DRG RATE SETTING METHODOLOGY

(a) Diagnosis Related Groups is a system of classification for hospital inpatient services. For each hospital admission, a single DRG category shall be assigned based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status. For claims with dates of services prior to January 1, 1995 payments shall be based on the reimbursement per diem in effect prior to January 1, 1995. However, for claims related to services where the admission was prior to January 1, 1995 and the discharge was after December 31, 1994, then the greater of the total per diem for services rendered prior to January 1, 1995, or the appropriate DRG payment shall be made.

(b) The Division of Medical Assistance (Division) shall use the DRG assignment logic of the Medicare Grouper to assign individual claims to a DRG category. Medicare revises the Grouper each year in October. The Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each rate year. The initial DRG in Version 12 of the Medicare Grouper, related to the care of premature neonates and other newborns numbered 385 through 391, shall be replaced with the following classifications:

385 Neonate, died or transferred, length of stay less than 3 days.

801 Birthweight less than 1,000 grams

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

802 Birthweight 1,000 - 1,499 grams

803 Birthweight 1,500 - 1,999 grams

804 Birthweight >=2,000 grams, with Respiratory Distress Syndrome

805 Birthweight >= 2,000 grams, premature with major problems

810 Neonate with low birthweight diagnosis, age greater than 28 days at admission

389 Birthweight >= 2,000 grams, full term with major problems

390 Birthweight >= 2,000 grams, full term with other problems or premature without major problems

391 Birthweight >= 2,000 grams, full term without complicating diagnoses

(c) DRG relative weights are a measure of the relative resources required in the treatment of the average case falling within a particular DRG category. The average DRG weight for all discharges from a particular hospital is known as the Case Mix Index (CMI). The statewide average CMI for all hospitals is utilized for out-of-state providers.

(1) The Division shall establish relative weights for each utilized DRG based on a recent data set of historical claims submitted for Medicaid recipients. Charges on each historical claim shall be converted to estimated costs by applying the hospital specific cost to charge ratio calculated by applying the individual cost to charge ratios from schedule C of each hospital's submitted Medicare cost report to each billed line item. Cost estimates are standardized by removing direct and indirect medical education costs at the appropriate rates for each hospital.

State Plan under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(2) Relative weights shall be calculated as the ratio of the average cost in each DRG to the overall average cost for all DRGs combined. Prior to calculating these averages, low statistical outlier claims shall be removed from the data set, and the costs of claims identified as high statistical outliers shall be capped at the statistical outlier threshold. The Division of Medical Assistance shall employ criteria for the identification of statistical outliers which are expected to result in the highest number of DRGs with statistically stable weights.

(3) The Division of Medical Assistance shall employ a statistically valid methodology to determine whether there are a sufficient number of recent claims to establish a stable weight for each DRG. For DRGs lacking sufficient volume, the Division shall set relative weights using DRG weights generated from the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Data Base Commission data set, the Division sets relative weights based upon the published DRG weights for the Medicare program.

(4) Relative weights shall be recalculated when the new version of the DRG Grouper is installed by the Division of Medical Assistance to be effective October 1 of the rate year. When relative weights are recalculated, the overall average CMI will be kept constant.

(d) The Division of Medical Assistance shall establish a unit value for each hospital which represents the DRG payment rate for a DRG with a relative weight of one. This rate is established as follows:

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(1) Using the methodology described in Paragraph (c) of this plan, the Division shall estimate the cost less direct and indirect medical education expense on claims for discharges occurring during calendar year 1993, using cost reports for hospital fiscal years ending during that period or the most recent cost report available. All cost estimates are adjusted to a common 1994 fiscal year and inflated to the 1995 rate year. The average cost per discharge for each provider is calculated. (See Exhibit page 25 of the plan). The state reserves the right to rebase based upon a year selected by the state.

(2) Using the DRG weights to be effective on January 1, 1995, a CMI is calculated for each hospital for the same population of claims used to develop the cost per discharge amount in Subparagraph (d)(1) of this plan. Each hospital's average cost per discharge is divided by its CMI to get the cost per discharge for a service with a DRG weight of one.

(3) The amount calculated in Subparagraph (d)(2) of this plan is reduced by 7.2% to account for outlier payments.

(4) Hospitals are ranked in order of increasing CMI adjusted cost per discharge. The DRG Unit Value for hospitals at or below the 45th percentile in this ranking is set using 75% of the hospital's own adjusted cost per discharge and 25% of the cost per discharge of the hospital at the 45th percentile. The DRG Unit Value for hospitals ranked above the 45th percentile is set at the cost per discharge of the 45th percentile hospital. The DRG unit value for new hospitals and hospitals that did not have a Medicaid discharge in the base year is set at the cost per discharge of the 45th percentile hospital. The actual reimbursement amount for a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. dsh and outliers).

State Plan under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(5) The hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated annually by the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget and Management. Effective October 1, 1997, for fiscal year ended September 30, 1998 only, the hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated by the lower of the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget and Management or the Medicare approved Inpatient Prospective Payment update factor.

(6) Allowable and reasonable costs will be reimbursed in accordance with the provisions of the Medicare Provider Reimbursement Manual referred to as HCFA Publication 15-1.

(e) Reimbursement for capital expense is included in the DRG hospital rate described in Paragraph (d) of this plan.

(f) Hospitals operating Medicare approved graduate medical education programs shall receive a DRG payment rate adjustment which reflects the reasonable direct and indirect costs of operating those programs.

(1) The Division defines reasonable direct medical education costs consistent with the base year cost per resident methodology described in 42 CFR 413.86. The ratio of the aggregate approved amount for graduate medical education costs at 42 CFR 413.86 (d)(1) to total reimbursable costs (per Medicare principles) is the North Carolina Medicaid direct medical education factor. The direct medical education factor is based on information supplied in the 1993 cost reports and the factor will be updated annually as soon as practicable after July 1 based on the latest cost reports filed prior to July 1.

(2) The North Carolina Medicaid indirect medical education factor is computed by the following formula:

$$1.89 ((1 + R)\ 0.405\ -1)$$

where R equals the number of approved full time equivalent residents divided by the number of staffed beds, not including nursery beds. The indirect medical education factor will be updated annually as soon as practicable after July 1 based on statistics contained in the latest cost reports filed prior to July 1.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(3) Hospitals operating an approved graduate medical education program shall have their DRG unit values increased by the sum of the direct and indirect medical education factors.

(g) Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services. These payments shall be subject to retrospective review by the Division of Medical Assistance, on a case-by-case basis. Cost Outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs for services that were not medically necessary or was for services not covered by the North Carolina Medical Assistance program.

(1) A cost outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of twenty-five thousand dollars ($25,000) or mean cost for the DRG plus 1.96 standard deviations.

(2) Charges for non-covered services and services not reimbursed under the inpatient DRG methodology (such as professional fees) shall be deducted from total billed charges. The remaining billed charges are converted to cost using a hospital specific total cost to total charge ratio not from the cost report but developed. The cost to charge ratio excludes medical education costs.

(3) If the net cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at 75% of the costs above the threshold.

(h) Day outlier payments are an additional payment made for exceptionally long lengths of stay on services provided to children under six at disproportionate share hospitals and children under age one at non-disproportionate share hospitals. These payments shall be subject to retrospective review by the Division of Medical Assistance, on a case-by-case basis. Day outlier payments will be reduced if and to the extent that the preponderance of evidence on review

supports a determination that the associated cost either exceeded the costs or was for services that were not medically necessary or for services not covered by the North Carolina Medical Assistance program.

(1) A day outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical average length of stay for the DRG plus 1.50 standard deviations.

(2) A day outlier per diem payment may be made for covered days in excess of the day outlier threshold at 75% of the hospital's payment rate for the DRG rate divided by the DRG average length stay.

(i) Services which qualify for both cost outlier and day outlier payments under this plan shall receive the greater of the cost outlier or day outlier payment.

EXCEPTIONS TO DRG REIMBURSEMENT

(a) Covered psychiatric and rehabilitation inpatient services provided in either specialty hospitals, Medicare recognized distinct part units (DPU), or other beds in general acute care hospitals shall be reimbursed on a per diem methodology.

(1) For the purposes of this Section, psychiatric inpatient services are defined as admissions where the primary reason for admission would result in the assignment of DRGs in the range 424 through 437. All services provided by specialty psychiatric hospitals are presumed to come under this definition.

For the purposes of this Section, rehabilitation inpatient services are defined as admissions where the primary reason for admissions would result in the assignment of DRG 462. All services provided by specialty rehabilitation hospitals are presumed to come under this definition.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(2) When a patient has a medically appropriate transfer from a medical or surgical bed to psychiatric or rehabilitative distinct part unit within the same hospital, or to a specialty hospital the admission to the distinct part unit or the specialty hospital shall be recognized as a separate service which is eligible for reimbursement under the per diem methodology.

Transfers occurring within general hospitals from acute care services to non-DPU psychiatric or rehabilitation services are not eligible for reimbursement under this Section. The entire hospital stay in these instances shall be reimbursed under the DRG methodology.

(3) The per diem rate for psychiatric services is established at the lesser of the actual cost trended to the rate year or the calculated median rate of all hospitals providing psychiatric services as derived from the most recent as filed cost reports. (See Exhibit page 25 of this plan)

(4) Hospitals that do not routinely provide psychiatric services shall have their rate set at the median rate for all other psychiatric hospitals in paragraph (3) above.

(5) The per diem rate for rehabilitation services is established at the lesser of the actual cost trended to the rate year or the calculated median rate of all hospitals providing rehabilitation services as derived from the most recent filed cost reports.

(6) Rates established under this Paragraph are adjusted for inflation consistent with the methodology under Subparagraph (d)(5) of the DRG RATE SETTING METHODOLOGY.

(b) To assure compliance with the separate upper payment limit for State-operated facilities, the hospitals operated by the Department of Health and Human Services and all the primary affiliated teaching hospitals for the University of North Carolina Medical Schools will be reimbursed their reasonable costs in accordance with the provisions of the Medicare Provider Reimbursement Manual. This Manual referred to as,

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(HCFA Publication #15-1) is hereby incorporated by reference including any subsequent amendments and editions. A copy is available for inspection at the Division of Medical Assistance, 1985 Umstead Drive, Raleigh, NC. Copies may be obtained from the U.S. Department of Commerce, National Technical Information Service, Subscription Department, 5285 Port Royal Road, Springfield, VA 22161 at a cost of one hundred forty seven dollars ($147.00). Purchasing instructions may be received by calling (703) 487-4650. Updates are available for an additional fee. Interim payment rates will be estimated by the hospital and provided to the Division of Medical Assistance subject to DMA review. These rates will be set at a unit value that can best be expected to approximate 100% of reasonble cost. Interim payments made under the DRG methodology to these providers shall be retrospectively settled to reasonable cost.

(c) When the Norplant contraceptive is inserted during an inpatient stay the current Medicaid fee schedule amount for the Norplant kit will be paid in addition to DRG reimbursement. The additional payment for Norplant will not be paid when a cost outlier or day outlier increment is applied to the base DRG payment.

(d) Hospitals operating Medicare approved graduate medical education programs shall receive a per diem rate adjustment which reflects the reasonable direct and indirect costs of operating these programs. The per diem rate adjustment will be calculated in accordance with the provisions of DRG RATE SETTING METHODOLOGY.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(e) A hospital licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50 percent of their Medicaid inpatient discharges for the fiscal year ending September 30, 1999 shall be entitled to a lump sum payment for the unreimbursed inpatient hospital services in an amount determined by the Director of Medical Assistance, subject to the following provisions:

(1) To insure that the payments authorized by this paragraph for public hospitals for the payment rate fiscal year 1999 that qualify under the criteria in Subparagraph A., below, do not exceed the upper limits established by 42 CFR 447.272:

(i) The lump sum payment is the reasonable cost of inpatient hospital Medicaid services, plus

(ii) the reasonable direct and indirect costs attributable to inpatient Medicaid services of operating Medicare approved graduate medical education programs, less Medicaid payments received or to be received for these services.

With respect to qualifying hospitals that are not public hospitals qualified under Subparagraph A, below, the maximum payment shall be calculated by ascertaining 67.43 percent of the unreimbursed reasonable cost as calculated by use of the same methodology in the previous paragraph. For purposes of this Subparagraph:

A. A qualified public hospital is a hospital that meets the other requirements of this Paragraph and:

(i) was owned or operated by a State (or by an instrumentality or a unit of government within a State) as of September 16, 1999 through and including September 30, 1999; and

(ii) verified its status as a public hospital by certifying State, local hospital district or authority government control on the most recent version of Form HCFA-1514 filed